IDAHO DEPARTMENT OF HEALTH & WELFARE

Healthy Connections Health Questionnaire

This survey asks you how you feel about your health.

- **Please complete one Health Questionnaire for each person, 5 years of age or older, who is applying for Medicaid benefits.**
- Parents or adult caretakers should complete the survey for children less than 14 years of age. When completing a survey on behalf of a child, please provide the **child's name, date of birth and social security number.**
- Anyone age 14 or older should complete their own survey.

Marking Instructions: Please fill in your responses with a #2 pencil or black pen, completely marking the appropriate bubbles.

Example: ○ Yes ● No

Your Name (Please carefully hand print your full name in the white box below)

Your Date of Birth
(please carefully hand print the month, day and year of your birth in the white boxes below mm/dd/yy):

Please enter your **Social Security Number** below. Carefully fill in the appropriate bubble for each digit.

			-			-			
○ 0	○ 0	○ 0		○ 0	○ 0		○ 0	○ 0	○ 0	○ 0
○ 1	○ 1	○ 1		○ 1	○ 1		○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2		○ 2	○ 2		○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3		○ 3	○ 3		○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4		○ 4	○ 4		○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5		○ 5	○ 5		○ 5	○ 5	○ 5	○ 5
○ 6	○ 6	○ 6		○ 6	○ 6		○ 6	○ 6	○ 6	○ 6
○ 7	○ 7	○ 7		○ 7	○ 7		○ 7	○ 7	○ 7	○ 7
○ 8	○ 8	○ 8		○ 8	○ 8		○ 8	○ 8	○ 8	○ 8
○ 9	○ 9	○ 9		○ 9	○ 9		○ 9	○ 9	○ 9	○ 9

1. Overall, how would you rate your health during the past 4 weeks?

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor ○ Very Poor

2. During the past 4 weeks, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

○ Not at all ○ Very little ○ Somewhat ○ Quite a lot ○ Could not do physical activities

3. During the past 4 weeks, have you been limited in any of the following activities due to HEALTH problems?

	Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
a. Doing things that take some energy such as riding a bike or skating?	○	○	○	○
b. Bending, lifting, or stooping?	○	○	○	○

4. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school, or other daily activities?

○ Not at all ○ Very little ○ Somewhat ○ Quite a lot ○ Could not do daily activities

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5. How much do you weigh (in pounds)?

(Write in your weight, in pounds, in the 3 boxes then carefully fill in the appropriate bubbles. If you weigh less than one hundred pounds, use the 2 right-most boxes.)

○ 0	○ 0	○ 0
○ 1	○ 1	○ 1
○ 2	○ 2	○ 2
○ 3	○ 3	○ 3
○ 4	○ 4	○ 4
○ 5	○ 5	○ 5
○ 6	○ 6	○ 6
○ 7	○ 7	○ 7
○ 8	○ 8	○ 8
○ 9	○ 9	○ 9

6. How tall are you?

(Write in the feet and inches in the boxes then carefully fill in the appropriate bubbles.)

feet	**inches**
○ 3 feet	○ 0 inches
○ 4 feet	○ 1 inch
○ 5 feet	○ 2 inches
○ 6 feet	○ 3 inches
○ 7 feet	○ 4 inches
	○ 5 inches
	○ 6 inches
	○ 7 inches
	○ 8 inches
	○ 9 inches
	○ 10 inches
	○ 11 inches

7. Would you like to lose weight? ○ Yes ○ No

8. Do you currently smoke? ○ Yes ○ No

9. Do you use other tobacco products (pipe, cigar, chewing tobacco)? ○ Yes ○ No

10. If you smoke or use other tobacco products, would you like to stop? ○ Yes ○ No

11. Have you ever been told by a doctor that you had one of the following chronic health problems?

a. Asthma or breathing problems? ○ Yes ○ No

b. Diabetes or high blood sugar? ○ Yes ○ No

c. High Blood Pressure? ○ Yes ○ No

d. Emotional Problems? ○ Yes ○ No

12. Have you ever been in an accident which caused you to be admitted to the hospital? ○ Yes ○ No

13. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition.

○ Within the past year (1-12 months ago)
○ Within the past 2 years (1-2 years ago)
○ Within the past 5 years (2-5 years ago)
○ 5 or more years ago
○ Not sure
○ Never

14. Do you have a particular doctor or clinic that normally provides your medical care? ○ Yes ○ No

If yes, please print the name and telephone number of your doctor or clinic in the box below.

15. To your knowledge, are you now pregnant? ○ Yes ○ No ○ Not sure

16. If yes, do you have a doctor or clinic providing prenatal care? ○ Yes ○ No ○ Not applicable